Basic Health I.D. #:_____ Health plan I.D. #:_____

Keep this book handy for quick reference.

2006 Member Handbook

Note: If you are enrolled in Basic Health through the federal Health Coverage Tax Credit (HCTC) program, Appendix B of this handbook (and information referenced there) applies to you.

Contact Information

	Customer Service Hours	Customer Service Phone Numbers	Web Site Address
Basic Health	24-hour self-service Mon. – Fri. 8 a.m. – 5 p.m.	1-800-842-7712 1-800-660-9840 TTY: 1-888-923-5622	www.basichealth.hca.wa.gov
Spanish	8 a.m. – 5 p.m.	1-800-321-0291	
Korean	8 a.m. – 5 p.m.	1-800-324-1658	
Vietnamese	8 a.m. – 5 p.m.	1-800-423-2231	
Russian	8 a.m. – 5 p.m.	1-800-387-8224	
Internal Revenue Service (to request federal income tax information)	Mon. – Fri.	1-800-829-1040	www.irs.gov
Health Coverage Tax Credit (HCTC) Program	Mon. – Fri. 5 a.m. – 5 p.m.	1-866-628-4282 TTY: 1-866-626-4282	www.irs.gov (Keyword: HCTC)
Columbia United Providers, Inc.	Mon. – Fri. 8 a.m. – 5 p.m.	1-800-315-7862 or 360-891-1520 TDD: 1-866-287-9962 or 360-449-8860	www.cuphealth.com
Community Health Plan of Washington	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-440-1561 TTY: 1-800-833-6388	www.chpw.org
Group Health Cooperative	Mon. – Fri. 8 a.m. – 5 p.m.	1-888-901-4636 TTY: 1-800-833-6388	www.ghc.org
Kaiser Foundation Health Plan of the Northwest	Mon. – Fri. 8 a.m. – 6 p.m.	1-800-813-2000 TTY: 1-800-324-8010	www.kaiserpermanente.org
Molina Healthcare of Washington, Inc.	Mon. – Fri. 7:30 a.m. – 5:30 p.m.	1-800-869-7165 TTY: 1-877-665-4629	www.molinahealthcare.com/washington

Basic Health	**Mailing Addresses**
Premium payments	P.O. Box 34270, Seattle, WA 98124-1270
General correspondence	P.O. Box 42683, Olympia, WA 98504-2683
Basic Health appeals (see page 20)	P.O. Box 42690, Olympia, WA 98504-2690

If you have any questions about...	Contact...
• **Adding and/or dropping coverage** • **Address changes** • **Income changes**	Basic Health at 1-800-842-7712 to get forms or hear recorded information; or 1-800-660-9840 to talk to a Basic Health representative; or go to **www.basichealth.hca.wa.gov.**
• **A bill for medical care** • **Choosing a provider** • **Covered services** • **Services received from providers** • **Waiting period**	Your health plan. (See the phone number on the previous page.)
• **Your medical care** • **Referrals to specialists**	Your primary care provider.
• **Your monthly premium** • **Your bill from Basic Health** • **Refunds**	Basic Health at 1-800-842-7712 for 24-hour, self-service payment information; or 1-800-660-9840, then follow the instructions to talk to an accounting representative.
• **Your family's enrollment** • **Your health plan** • **Your premium**	Visit **www.basichealth.hca.wa.gov/ecoverage/shtml**.

When you call or write to us...

Be sure to include your **name, Basic Health I.D. number, address,** and a **daytime phone number.** Be sure to note the date of the call, the name of the person you talked to, and the organization you contacted. If you have Basic Health through your employer, a home care agency, or a financial sponsor, first contact your representative (usually your payroll officer or financial sponsor representative). (S)he may have the information you need, or may need to know about a change you're making.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Si desea ayuda en español, llame al 1-800-321-0291.

Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.

한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오.

Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

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Introduction

Basic Health offers quality, low-cost health coverage to eligible people who live in Washington State. It is a state program managed by the Washington State Health Care Authority (HCA). The HCA contracts with health plans to offer Basic Health and Basic Health *Plus* coverage. Each health plan works with hospitals, clinics, pharmacies, physicians, and other providers to serve Basic Health and Basic Health *Plus* members.

If any of your family members are enrolled in Basic Health *Plus* or the Maternity Benefits Program, you should have received *A Guide to Basic Health Plus and the Maternity Benefits Program*, with specific information about these programs.

You must give Basic Health the information needed to determine your continued eligibility for the program. You must also give your health plan all information they need to process claims, including medical records.

If you are enrolled in Basic Health as a Health Coverage Tax Credit (HCTC) enrollee, read Appendix B of this handbook first.

You must follow your health plan's rules to get the benefits described in this handbook. Rules may be different between health plans. Be sure to read your health plan's materials for details, and call them if you have questions about your benefits.

This handbook is your "certificate of coverage." It describes what Basic Health covers, and the rules you must follow when using your coverage. This handbook is subject to the state laws governing Basic Health (Chapter 70.47 RCW) and the administrative rules of Basic Health (Chapter 182-25 of the Washington Administrative Code). If there are any conflicts between this handbook and the law, the law governs.

Keep this *Member Handbook* handy, and look at it when you have a question about your benefits. Basic Health may send other important documents, such as *Hot Policy Pages* and open enrollment materials. These may include updates to this handbook. Always keep them with your *Member Handbook*.

Throughout this handbook, "you" generally refers to the main subscriber on the Basic Health account or to an adult who will be reading and referring to coverage information on behalf of an enrolled child.

Chapter One:
Eligibility for Basic Health Programs

Basic Health is available to anyone who lives in Washington and:

- **Meets income guidelines (see pages 5–6);**
- **Is not eligible for free or purchased Medicare;**
- **At the time of enrollment, is not confined in or living in a government-funded institution that has historically provided health care; and**
- **Is not attending school full-time in the United States on a student visa.**

Specific programs may have additional eligibility requirements. Basic Health is also available to people eligible for the Health Coverage Tax Credit through the Internal Revenue Service (IRS), whether or not they meet the above criteria.

Family members who should be listed as dependents on your account (even if they are not enrolling for coverage) include:

- **Your spouse living in the same house and not legally separated from you.**
- **Your unmarried child, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship, who is:**
  - Under age 19; or
  - Under age 23 and a full-time student at an accredited school. You are required to send proof from the school each year when your dependent is age 19 through 22, to show that he or she is a full-time student. If your dependent over age 18 is no longer a full-time student, you must notify Basic Health within 30 days of this change.
- **Your unmarried child under age 19, enrolling for Basic Health coverage, and in your custody under an informal guardianship agreement that is signed by the child's parent(s) and allows you to get medical care for the child. To request coverage for a child living with you under such an agreement, you must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. You cannot list a child who is in your home under a foster care agreement.**
- **Your unmarried child, stepchild, legally adopted child, or legal dependent of any age who cannot take care of him- or herself due to disability. You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.**

Family members who are not eligible for coverage on your account may be able to enroll separately—for example, a child who reaches age 19 and is not disabled or attending school full time. This family member must complete a separate Basic Health application.

Family enrollment

Individuals may apply for Basic Health, Basic Health *Plus*, the Maternity Benefits Program, or other programs for themselves and qualified family members. You and your family members may be enrolled in different programs. For example, you may enroll in Basic Health, your spouse in the Maternity Benefits Program, and your child in Basic Health *Plus*.

Premiums

Premium payments are due by the 5th day of the month before the actual month of coverage; the amount and due date are shown on each month's bill. Your bill is sent about six weeks before the month to be covered by that payment. For example, the bill for August coverage is sent mid-June and payment is due July 5.

If the entire premium is not paid on time, Basic Health will send a late notice. This notice will include the bill for both the past due amount (called the delinquent balance) and the premium for the following month's coverage. Basic Health must

receive payment for each amount due by the due date given, or your coverage will be suspended for one month. Partial payment or checks that cannot be processed (for example, insufficient funds or missing a signature) will be considered nonpayment and may cause you to lose coverage. For more information, refer to page 13.

Basic Health *Plus*

Basic Health *Plus* is a Basic Health and Department of Social and Health Services (DSHS) program for children under age 19. With Basic Health *Plus*, children receive additional health care coverage such as dental care, vision care, and physical therapy. Children enrolled in Basic Health *Plus* receive services through the same health plan that provides your Basic Health coverage.

Your family will have to meet DSHS's income guidelines, available on their Web site (**https://wws2.wa.gov/dshs/onlinecso/Medical.asp**). The children must be your legal dependents, live in your home, and be:

- **Under age 19;**
- **U.S. citizens, or immigrants who have legally lived in the U.S. for five years;**
- **Not enrolled in any other managed care plan, including TRICARE; and**
- **Not receiving Temporary Assistance for Needy Families (TANF) grants from DSHS.**

For some Basic Health *Plus* services, such as dental and vision care, the state pays the provider directly.

If you would like to transfer your child's coverage from Basic Health to Basic Health *Plus*, call 1-800-842-7712 or visit our Web site (**www.basichealth.hca.wa.gov**) to request a Basic Health *Plus* application.

Maternity Benefits Program

The Maternity Benefits Program is a Basic Health and DSHS program that provides pregnant women with full maternity coverage, usually through the same providers and health plan chosen for Basic Health coverage. See page 23–24 for more information on maternity coverage.

Basic Health for foster parents and personal care workers

If you are currently licensed by DSHS as a foster parent or under contract with DSHS as a personal care worker, and meet Basic Health income guidelines, you may be able to pay even less for Basic Health coverage.

For more information or to request a foster parent or personal care worker application, call 1-800-660-9840 or check Basic Health's Web site.

Basic Health through your employer, financial sponsor, or home care agency

Employers, home care agencies, and financial sponsors may enroll their employees or sponsored members in Basic Health. Your employer or sponsor pays your premium, but may collect part of it from you. Your main contact with Basic Health will be through your employer or sponsor.

If your employer, home care agency, or financial sponsor doesn't pay the premium on time, or if you no longer qualify for coverage through them, you may be disenrolled. If your entire organization is disenrolled, Basic Health will offer you individual coverage; however, you may have a break in coverage.

Health Coverage Tax Credit

If you are enrolled in Basic Health through the federal Health Coverage Tax Credit (HCTC) program, please read Appendix B of this handbook. If you are not enrolled in HCTC-Basic Health, but think you may qualify, call 1-866-628-4282, or visit **www.irs.gov** (keyword: HCTC).

Chapter Two:
Income Guidelines

How your income is calculated

Basic Health requires current pay stubs and a copy of your IRS Form 1040 for the most recent tax year, with all schedules filed. We will look at the income from both sources and use the one that gives the best picture of your income.

If you cannot provide IRS documentation (you were not required to file a tax return), we will use your most recent income documentation, unless your income is seasonal. If Basic Health determines that your income is seasonal, we will use an average of your income over several months. You may be required to provide additional documentation.

If you are reporting self-employment or rental income, Basic Health will use a 12-month average of that income, unless you have had the business or rental property for less than 12 months. When figuring your self-employment income, Basic Health will not deduct depreciation, amortization, or business use of your home. A net loss from this calculation will not be used to offset other income sources (a loss equals zero).

If you paid for child care or for the care of a disabled dependent so you and/or your spouse could work or go to school, you may be allowed to deduct expenses, up to a maximum of $650 per month per child or disabled dependent. Documentation showing the amount paid and to whom is required. (This will not count if paid to the child's parent or stepparent, or to another dependent of the main subscriber.) If the expenses were for the care of a disabled dependent, you will be required to provide documentation of the disability and proof that the dependent cannot care for himself/herself and, if the care is during school hours, that (s)he cannot attend public schools.

Eligibility and premiums for most Basic Health programs are based on gross family income, which is adjusted according to the number of people in the family (the "income band" for the family). The following table shows the income bands used for determining eligibility and premiums through June 2006. After June 30, 2006, please check our Web site (**www.basichealth.hca.wa.gov**) or call1-800-660-9840 for information. To find your income band, find your family size and your family's **gross** monthly income (before taxes and other deductions).

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

Income Table

Gross Monthly Income	Number of People in Your Family							Income Band
	1	2	3	4	5	6	7	
	$0 – $518.37	$0 – $694.95	$0 – $871.54	$0 – $1,048.12	$0 – $1,224.70	$0 – $1,401.29	$0 – $1,577.87	A
	518.38 – 797.49	694.96 – 1,069.16	871.55 – 1,340.83	1,048.13 – 1,612.49	1,224.71 – 1,884.16	1,401.30 – 2,155.83	1,577.88 – 2,427.49	B
	797.50 – 996.87	1,069.17 – 1,336.45	1,340.84 – 1,676.04	1,612.50 – 2,015.62	1,884.17 – 2,355.20	2,155.84 – 2,694.79	2,427.50 – 3,034.37	C
	996.88 – 1,116.49	1,336.46 – 1,496.83	1,676.05 – 1,877.16	2,015.63 – 2,257.49	2,355.21 – 2,637.83	2,694.80 – 3,018.16	3,034.38 – 3,398.49	D
	1,116.50 – 1,236.12	1,496.84 – 1,657.20	1,877.17 – 2,078.29	2,257.50 – 2,499.37	2,637.84 – 2,920.45	3,018.17 – 3,341.54	3,398.50 – 3,762.62	E
	1,236.13 – 1,355.74	1,657.21 – 1,817.58	2,078.30 – 2,279.41	2,499.38 – 2,741.24	2,920.46 – 3,203.08	3,341.55 – 3,664.91	3,762.63 – 4,126.74	F
	1,355.75 – 1,475.37	1,817.59 – 1,977.95	2,279.42 – 2,480.54	2,741.25 – 2,983.12	3,203.09 – 3,485.70	3,664.92 – 3,988.29	4,126.75 – 4,490.87	G
	1,475.38 – 1,595.07	1,977.96 – 2,138.44	2,480.55 – 2,681.80	2,983.13 – 3,225.16	3,485.71 – 3,768.52	3,988.30 – 4,311.88	4,490.88 – 4,855.24	H

Valid through June 30, 2006

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

Chapter Three:
Making Changes and Maintaining Eligibility

Changes to your account could affect your Basic Health coverage. They must be reported to Basic Health within the timelines noted in this chapter. You may use the *Change Form* included with your monthly bill to make some account changes. To get other forms, call our 24-hour, automated, self-service phone line, 1-800-842-7712, or visit our Web site. You may also write to Basic Health at PO Box 42683, Olympia, WA 98504-2683.

If you are enrolled through your employer or a financial sponsor, make sure he or she knows about changes in your income or family, too, because it may affect the amount you pay for your coverage. Contact your financial sponsor, employer, or payroll office if you have questions.

Changing health plans

Open enrollment is the time each year when you can change your health plan (if you have more than one plan available in your area), except as noted elsewhere in this section. At open enrollment, Basic Health will send you information about any changes to your coverage, and will tell you about health plans in your area and their monthly premiums. You'll be notified before each open enrollment and given instructions for making changes.

Other than during open enrollment, you may only change health plans under certain conditions. These are explained later in this chapter. You cannot change health plans because your provider is no longer with your health plan. (An exception may be made in some cases if you can prove that you need to continue a current course of treatment with a specific provider.) When you change health plans, remember that each health plan contracts with different providers and has its own list of prescription drugs. Call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription drugs, contact the health plan to see if they will be covered.

If you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Also, your deductible and out-of-pocket maximum will start over. Check with your health plan for further information.

Basic Health will do its best to make sure your health plan is available throughout the year. However, if your health plan becomes unavailable, you will be asked to choose one of the plans in your county. If only one health plan remains, you will be assigned to that plan.

Address changes

You must give Basic Health your new address within 30 days of a change. You may call Basic Health at 1-800-660-9840, complete and return the *Change Form* included with your bill, or write to Basic Health at PO Box 42683, Olympia, WA 98504-2683. Include your Basic Health I.D. number, your name, new address and county, your old address, and your new phone number. Be sure to say if your new address is permanent or temporary (less than three months), and if your mailing address is different from your street address.

If you move out of Washington State, you will be disenrolled from Basic Health. If you move out of your health plan's service area, you will have to

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

select a new health plan. If your current health plan is still available to you, but would cost more, or you have plan choices that weren't available before you moved, you may request a plan change. While you are waiting to be transferred to your new health plan, you will need to keep using your old health plan for anything except emergency services. When you change health plans, your deductible and out-of-pocket maximum will start over.

Please note: Basic Health double-checks addresses with the U.S. Postal Service, so be sure to file any change of address with your post office.

Dependent living away from home

If your dependent is living away from home, as described below, Basic Health will cover only emergency care while (s)he is out of state or staying in a county that is not served by your health plan. Routine services should be scheduled when (s)he is home.

Out of county

If your child lives in a different county, you may be able to choose a health plan that provides service to both your home county and the county (s)he lives in. When necessary, Basic Health allows your dependent to enroll in a different health plan under a separate account so that (s)he may receive services in the county where (s)he lives. You will be sent a separate bill for that account.

Out of state

If your child is a Washington State resident, but lives away from home part of the time (to attend college, for example), (s)he may be eligible to receive Basic Health coverage as long as (s)he remains a Washington State resident and returns to Washington State during scheduled breaks. You may be required to provide proof of out-of-state tuition or that the child's residence is in Washington State.

Family changes

Eligible family members may enroll in Basic Health during open enrollment. You will get information telling you how to enroll a family member at that time.

Family members may be added, removed, or enrolled at other times during the year, based on the guidelines below, by completing and submitting a *Family Changes Form*. Adding, enrolling, or removing a family member may change your monthly premium. You will get written verification of any changes to your account. Also, if the number of family members living in your home goes down, you may no longer be eligible for Basic Health.
If you do not report changes to your account in the required timeframe, you may be disenrolled.
To make any family changes to your account, call 1-800-842-7712 or visit Basic Health's Web site to request the *Family Changes Form*. When you notify Basic Health of a change in family size (such as birth, marriage, divorce, or death), you will be required to submit proof of your current income and Washington State residence.

- **Loss of or transfer from other continuous coverage:** If you or a family member either left or chose not to enroll in Basic Health coverage

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

because you or they had other health care coverage, and then that person loses or wants to transfer from that coverage, the request must be received by Basic Health within 30 days of the loss of coverage. You must show proof of the other continuous coverage.

- **Enrolling a new family member:** To enroll a new spouse, child, or dependent, Basic Health must receive the appropriate application within the timeframes below. Otherwise, the family member will be counted for family size when figuring your monthly premium, but will not have coverage.
  - **Marriage:** Within 30 days of the date of your marriage.
  - **Newborn or newly adopted child:** Within 60 days of the birth or placement for adoption.
  - **Other dependents** (students age 19 through 22, adult with disability): Within 30 days of the date they become your dependent or move into your home. See page 3 for details.

Removing family members: Basic Health needs notice of the following changes within the required timeframes.

- **Divorce/separation:** We must receive notice within 30 days of the divorce/separation. If you get back together and are living in the same home, you must tell Basic Health in writing, and we will stop the separation of your account.
- **Transfer of a former student to separate account:** You must notify Basic Health within 30 days of the date the person stops attending school full time. A former student who is taken off the parents' account because he or she is no longer a full-time student may apply for coverage on a separate account.

When coverage begins for added family members

If you get married and follow the procedures explained in "Family changes" (above), coverage for your new family members will begin on the first day of the month after eligibility has been determined and full payment is received.

Your newborn or adopted child is covered from the date of birth or placement in your home if you or a family member is enrolled in Basic Health or Basic Health *Plus*, and if Basic Health receives the application for the child within 60 days of the birth or placement. If Basic Health receives your application more than 60 days after the child's birth or placement, your child will be included for family size only when calculating your premium (this usually reduces your premium), but will not have medical coverage. See page 8 for more information.

Income changes

If your income changes, your monthly premium or eligibility for Basic Health may change, too. You must report any income change to Basic Health within 30 days of the end of the first month at the new income. You must continue paying your premium as billed until we tell you the new premium amount. (See additional information on pages 10–11.)

If you begin receiving social security disability benefits, you must notify Basic Health immediately. This may affect your eligibility for Basic Health.

When sending income information to Basic Health, use the list below. If this list changes, you will get an update. Keep all updates with this handbook.

Include **proof of all income received from the following sources:**

- Salaries, wages, commissions, tips, work-study, training stipends, or assistantships, including bonuses
- Self-employment
- Rental property
- Unemployment
- Strike benefits
- Social security retirement, survivor, disability, or supplemental security income (including money received by dependent children)
- Retirement and pensions
- Child support or alimony

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

- Insurance benefits and compensation for an injury (other than reimbursement for a loss or medical costs), including workers' compensation
- Interest, dividends, periodic receipts from a trust, net capital gains, and royalties
- Veterans' benefits and military allotments
- Public assistance (DSHS cash assistance)
- Estate income
- Net gambling/lottery winnings
- All other income that's not specifically in the "Income does not include" list, below

Income does *not* include:

- Income, such as wages, earned by dependent children (however, you must include distributions from a corporation, partnership, or business, even if distributed to a child)
- Any assets drawn down as withdrawals from a bank, or proceeds from the sale of property, such as a house or car
- Tax refunds, gifts, or loans
- Income from a family member who lives in another household, when that income is not available to you or eligible dependents
- University scholarships, grants, or fellowships
- Non-cash benefits (such as food stamps, school lunches, or housing in lieu of wages)
- Payments for adoption support received from the Department of Social and Health Services
- IRA distributions

Reporting income changes

Send a *Family Income Reporting Form*, along with documentation of current income and IRS documentation for the most current tax year. You may get this form by calling 1-800-842-7712, or visiting our Web site. (See "Recertification" for acceptable IRS and income documentation.)

- Include documentation of childcare expenses up to $650 per child, if the childcare was necessary for both parents to work or attend school

Basic Health will send you a *Personal Eligibility Statement.* It will show any changes to your account that affect your monthly premium or eligibility for the program. It may include a bill for an additional amount you must pay as a result of the change.

Recertification

Basic Health is required by state law to periodically review members' income and eligibility for the program. This is called "recertification." Under this process, Basic Health members are required to send in proof of income, benefits, and Washington State residency. Being selected for recertification does not mean Basic Health believes you have given us the wrong information; it is a legal requirement for all of our members. If you have to wait for Basic Health coverage because the program is full, you may be recertified soon after your coverage begins.

If you get a recertification notice, Basic Health must receive all documentation requested by the due date given. Otherwise, you and your covered family members will lose your coverage for at least 12 months. If you reapply for Basic Health at the end of the 12 months, you will have to provide proof of income and eligibility at that time. Even if you are found eligible, if Basic Health is full, you will also have to wait until space is available.

To complete your recertification, you will be required to send all of the following:

- **Proof that you live in Washington State.**
- **The *Recertification Form*** sent to you, signed by any enrolled family members age 18 and over.
- **A copy of one of the following** for the most current tax year:
  - Your IRS Form 1040 (federal income tax form) and all schedules
  - IRS transcript of your return, if you do not have a copy of your IRS Form 1040
  - Verification of non-filing from the IRS if you were not required to file a tax return (non-filing status)
- **Copies of pay stubs** for the last 30 days for you and your spouse.

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

- **Written proof of all other income and benefits** received by your family for the last 30 days.
- **If you are self-employed or have rental income,** a copy of all business forms and schedules filed with the IRS, a complete copy of your Schedules K-1 (if applicable), and a *Self-Employment/Rental Income Reporting Form* if you:
  - Were not required to file a tax return; or
  - Have been in business for less than 12 months.

You will be given more details on exactly what is required when you are selected for recertification.

What if I don't report a change in income?

Your monthly premium is based in part on your income, so you must report changes in your income to Basic Health. We check with other sources to make sure your reported income is accurate. If we find that you have not reported an income change, you must pay the difference between the premium you paid and the premium you should have paid.

If this happens, Basic Health will send you a notice showing the amount we believe you owe the state. If you believe you do not owe the amount shown on that notice, you must follow the instructions in the notice. If you do not respond, or if you are unable to prove that the amount of income you reported to us was correct, Basic Health will bill you for the amount you owe.

What if I don't repay the amount I owe?

If you are billed, you must pay based on the billing schedule we provide. If you do not pay your full bill on time, you will lose your Basic Health coverage. (See page 13 for more information.) If you do not repay the total amount, your account will be sent to a collection agency and you will also have to pay any fees charged by the collection agency.

Legal penalties

Basic Health may bill you for twice the amount due if you:

- Intentionally provide misleading or false income information, or
- Withhold information about income.

If you intentionally provide false or misleading information or withhold information, Basic Health may take additional legal action, such as:

- Prosecution for perjury, and
- Immediate disenrollment back to the date your coverage would have been affected. This means that we will bill you for the total cost of your health coverage since that date.

In addition, if your health plan has paid for services during a time you were enrolled through fraud, they may demand you repay them.

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

Chapter Four:
Suspension, Disenrollment, and Reenrollment

Suspension

If you (or your financial sponsor or employer, if enrolled through them) do not pay your premium on time, you will lose coverage for one month. If your premium is paid in full by the due date on your notice of suspension, you will be reenrolled the next month. If you lose coverage for one month, any payments you have made toward your deductible and out-of-pocket maximums will still count.

Disenrollment

To stop Basic Health or Basic Health *Plus* coverage for yourself, a family member, or your entire family, call 1-800-660-9840, or write to Basic Health, PO Box 42683, Olympia, WA 98504-2683. You must include:

- Your name and Basic Health I.D. number;
- The name of each person you want to disenroll;
- The reason you want to disenroll (especially if due to other insurance, Medicare, or Medicaid); and
- The date you want coverage to end. We need to receive your request to disenroll at least 10 days before the first of the month you want coverage to end.

You are no longer eligible for Basic Health and will be disenrolled if you:

- Leave Washington State with no plan to return, or if you are gone for more than three months in a row.
- Become eligible for free or purchased Medicare coverage, regardless of whether you actually have Medicare coverage.
- Have income above Basic Health's income guidelines.

If you are disenrolled because you became ineligible (as described above) and your circumstances change, you may reapply for Basic Health coverage, but may have to wait until space is available.

You will be disenrolled from Basic Health and will not be allowed back in for at least 12 months if you:

- Are suspended for nonpayment three times in a 12-month period, or do not reenroll the month following a one-month suspension.
- Are billed for the amount Basic Health overpaid for your coverage, and you do not pay the amount based on the billing schedule we provide. (See "What if I don't report a change in income?" on page 11.)
- Do not provide documentation Basic Health asks for to check your eligibility or income.
- Take part in any abuse, intentional misconduct, or fraud against Basic Health or your health plan or its providers, or knowingly give information to Basic Health that is false or misleading.
- Intentionally withhold required information, such as a change in income or family size.

You may also be disenrolled from Basic Health if you:

- Purposely put the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors, at risk.
- Refuse to follow procedures or treatment recommended by your provider and determined by your health plan's medical director to be essential to your health or the health of your child, and you have been told by your health plan that no other treatment is available.

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

- Repeatedly fail to pay copayments, coinsurance, or other cost-sharing requirements on time.
- Withhold from your health plan information you have about a legally responsible third party, or refuse to help your health plan collect from that legally responsible third party.

The above conditions for loss of coverage also apply to family members enrolled on your Basic Health account.

Family members enrolled in Basic Health *Plus* or the Maternity Benefits Program through DSHS may stay with these programs as long as they are eligible, even if your coverage is suspended for one month or you are disenrolled from Basic Health for failing to pay your required premium.

If your coverage ends, you will receive written notice of the reason and the date your coverage ends.

Disenrollment from employer, financial sponsor, or home care agency coverage

If you have Basic Health coverage through your employer, you may be able to continue your coverage through the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, you can continue coverage for up to 18 months; however, you will have to pay the full cost of that coverage, including any premium share that had been paid by your employer. Contact your employer to find out if you qualify for COBRA coverage.

If you are no longer eligible for employer, home care agency, or financial sponsor coverage, but still qualify for individual Basic Health, Basic Health will offer you coverage on your own account. If you get an offer from us, you must tell us right away if you want to transfer to your own account. If you do, you must pay the premium for your continued coverage.

Reenrollment

The reenrollment process depends on the reason your Basic Health coverage ended and the amount of time since you last had coverage. When you reapply for Basic Health, you may be required to send in a new application, proof of income and residency, and proof of other continuous coverage.

Generally, when you disenroll from Basic Health, you have to wait at least 12 months before you can reenroll, and may also have to wait until space is available. However, the 12-month wait for reenrollment may be waived if:

- You left for other coverage, and you reapply for Basic Health within 30 days of losing other continuous coverage (you will be required to provide proof of other coverage);
- You move out of the state, then move back to stay; or
- You were disenrolled because you were no longer eligible for Basic Health coverage, but you are now eligible again.

Even if the 12-month wait for reenrollment is waived, if Basic Health is full, you will have to wait until space is available.

The information in chapters 2-4 does not apply to HCTC-Basic Health members.

Chapter Five:
Rights, Responsibilities, and Privacy

Basic Health member rights

As a Basic Health member, you have the right to:

- Get understandable notices or have the materials explained or interpreted.
- Receive timely information about your health plan.
- Get courteous, prompt answers from your health plan and Basic Health.
- Be treated with respect.
- Have your privacy protected by Basic Health, your health plan, and its providers.
- Get information about all medical services covered by Basic Health.
- Choose your health plan and primary care provider from among available health plans and their contracted networks.
- Receive proper medical care, consistent with Appendix A of this handbook, without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, or religion.
- Get all medically necessary covered services and supplies listed in the Basic Health Schedule of Benefits, subject to the limits, exclusions, and cost-sharing described in Appendix A.
- Take part in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage.
- Get medical care without a long delay.
- Refuse treatment and be told of the possible results of refusing, including if your refusal may result in disenrollment from Basic Health.
- Expect your and your child's records and conversations with providers to be kept confidential.
- Get a second opinion by another provider in your health plan when you disagree with the initial provider's recommended treatment plan.
- Make a complaint about the health plan or providers and receive a timely answer.
- File an appeal with your health plan or Basic Health if you are not satisfied with their decision (see pages 19–20).
- Receive a review of a Basic Health appeal decision, if you disagree with it.
- Change your primary care provider for a good reason (call your health plan for assistance).

Basic Health member responsibilities

As a Basic Health member, you and/or your enrolled dependents have the responsibility to:

- Understand Basic Health.
- Accurately and promptly report changes that may affect your premium or eligibility, such as an address change, or a change in family status or income, and send in the required forms and documentation. (Read Chapters Two and Three for timelines and instructions.)
- Choose a health plan in your area.
- Choose a primary care provider from your health plan before receiving services.
- Work with your health plan to help get any third-party payments for medical care.
- Tell your health plan about any outside sources of health care coverage or payment, such as insurance coverage for an accident.
- Tell your or your child's primary care provider about medical problems, and ask questions about things you do not understand.
- Decide whether to receive a treatment, procedure, or service.
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral.
- Get a referral from the primary care provider before you or your child goes to a specialist.
- Pay copayments in full at the time of service.
- Pay your Basic Health premiums in full by the due date.
- Pay your deductible and coinsurance in full when they are due.
- Not engage in fraud or abuse in dealing with Basic Health, Basic Health *Plus*, the Maternity Benefits Program, your health plan, your primary care provider, or other providers.
- Keep appointments and be on time, or call the provider's office when you or your child will be late or can't keep the appointment.
- Keep your family members' medical I.D. cards with the family member at all times, or with you if your children are young.
- Notify the health plan or primary care provider within 24 hours, or as soon as is reasonably possible, of any emergency services provided outside the health plan.
- Use only your selected health plan and primary care provider to coordinate services for your family's medical needs.
- Comply with requests for information, including requests for medical records or information about other coverage, by the date requested.
- Cooperate with your primary care provider and referred providers by following recommended procedures or treatment.
- Work with your health plan and providers to learn how to stay healthy.

Informed consent

You have the right to give your consent to treatment or care. Be sure to ask your provider about the side effects of your or your child's care. You have the right to know about them, and give your consent before getting care.

Advance directives

"Advance directives" put your health care choices into writing. They may also name someone to speak for you if you are not able to speak. Before signing such a document, talk to a lawyer or legal counselor. Washington State law has two kinds of advance directives:

1. **Durable Power of Attorney for Health Care –** Names someone to make medical decisions for you if you are not able to make them for yourself.
2. **A Directive to Physicians (Living Will) –** A document that lets you tell your doctor what you do or do not want done if you have a terminal condition or are permanently unconscious.

Privacy

Personal health information

The Health Care Authority will not release any personal health information that is provided verbally, electronically, or in writing to anyone but you or your health plan without your prior written

authorization. Exception: Basic Health and DSHS may exchange information about your pregnancy.

Account information

Without your written permission, the HCA cannot release personal account details such as eligibility, enrollment, monthly premium, or payment to anyone but you or your health plan.

Exceptions:

- If your employer, a home care agency, or a financial sponsor is paying your premium, limited information may be released to your representative. Ask him or her for details.
- Information about a dependent minor child will be released to either parent.
- Your information may be shared with DSHS if DSHS is paying any part of your premium (for example, if you are applying for or enrolling in Basic Health *Plus* or the Maternity Benefits Program, or as a foster parent, personal care worker, or home care worker).
- Providing information to law enforcement.

If you want to let someone else (such as a friend or a relative) access or make changes to your account, you need to send written permission to Basic Health. Be sure to sign and date your letter and include the person's name, their relationship to you, and what information you want released to them or changes they can make. Only the information you specify will be released. You will also need to tell us if this permission is for a specific time period or for as long as you are enrolled in Basic Health. When this person calls, they'll need your Basic Health I.D. number, and will be asked for other identifying information.

The HCA privacy notice is available on request by calling 360-923-2822 or online at **www.hca.wa.gov.**

Chapter Six:
Grievances, Complaints, and Appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this book. If you disagree with the determination of your ineligibility for the Health Coverage Tax Credit, contact the HCTC Customer Contact Center for information. (See Appendix B for HCTC contact information.) If you have a complaint about an action taken by Basic Health, call 1-800-660-9840. If you call Basic Health or your health plan, be sure to note the date of the call, the name of the person you talked to, and whether that person was with Basic Health or your health plan.

Your health plan is required to give you information on its grievance and appeals process when you:

- Enroll,
- Annually or whenever there is a change to their grievance and appeal process, and
- When the health plan sends you a notice of a denial of a benefit or service, or notice of an appeal decision.

Grievances against your health plan

If you disagree with a decision made by your health plan (such as a denial of a claim or benefits interpretation) or have a grievance regarding your health plan's services, providers, or facilities, you must follow your health plan's procedures for resolving the problem. Basic Health staff are available to help you resolve the issue informally, but the matter cannot be appealed to Basic Health. You may file a grievance in writing, in person at the health plan's office, or over the phone. The health plan will help you with this process.

If you file a grievance with your health plan, the health plan must respond within 30 days after receiving it. If you file a grievance against a health plan's service, provider, or facility, Washington State law limits the information the health plan may provide you regarding the resolution of your grievance.

Appeals to your health plan

If you are denied a service, or the health plan changed a service that was already approved, you may file an appeal. An appeal is a request for the health plan to review its decision. You may file an appeal or a grievance in writing, in person at the health plan's office, or over the phone. The health plan will help you with this process.

When you file an appeal with your health plan:

- Within five working days, the health plan will send you a letter saying they've received your appeal.
- Within 14 calendar days, your health plan must respond to you in writing with either a decision or notification of a reason for a delay. However, unless you agree to an additional delay, the decision must be made within 30 calendar days after the health plan receives your appeal.

If waiting for a decision could put your health at risk, you can ask, or have your provider ask, for an expedited (quick) review. The health plan will make a decision within 72 hours after receiving an expedited appeal.

If you have gone through your health plan's appeal process and disagree with their decision, or if your health plan has not responded to you within the timelines referenced above, you have the right to request a review of the decision by an Independent Review Organization (IRO). This is done through your health plan and at no cost to you. Your health plan is required by law to give the IRO all information used in making its decision within three business days of receiving the request. You may also be required to provide additional information or documentation needed for the IRO's decision. If waiting for a decision could put your health at risk, you can ask for an expedited (quick) review. The IRO

will make a decision within 72 hours. The health plan will let you know the outcome.

You may choose someone, including an attorney or provider, to serve as your personal representative to act on your behalf for the appeal. The health plan must receive written consent from you allowing this person to represent you before the person can act on your behalf. Contact your health plan for additional information.

Complaints against Basic Health

If you have a complaint or want an explanation of an action Basic Health has taken on your account, write to Basic Health at PO Box 42683, Olympia, WA 98504-2683, or call 1-800-660-9840. A representative will try to resolve your issue.

Appeals to Basic Health

If you disagree with a Basic Health decision, such as premium calculation, premium adjustment or penalty, change of health plan, denial of Basic Health eligibility, or loss of Basic Health coverage, you may file a written appeal with Basic Health within 30 days of the notice of the decision. Write to Basic Health Appeals, PO Box 42690, Olympia, WA 98504-2690, stating you want to file an appeal. Your letter must include your name, address, Basic Health I.D. number, a daytime phone number, a summary of the decision you are appealing, and a statement explaining why you believe the decision was incorrect. You must also include copies of any evidence that will help explain or prove that the decision should be changed. If your appeal is not received within 30 days of the notice of the decision, you will lose your right to appeal that decision.

In your appeal, you may ask to explain in person or by phone why you believe the decision was incorrect and should be changed. Be sure to let us know if you will need an interpreter and, if so, what language and dialect you speak. Also let us know if you will need any assistance due to disability.

Within five days of receiving your letter, Basic Health will confirm that your appeal was received. If you have asked to explain your appeal over the phone or in person, our Appeals Department will contact you to schedule a conference. The conference will be recorded to ensure an accurate record, and you will be questioned as well as given an opportunity to explain your point of view. You should be prepared to give detailed information to support your opinion that the decision was in error.

Your appeal will be reviewed carefully, and Basic Health will mail a written notice of the decision to you within 60 days of receiving your appeal. If additional time is required for investigation of your appeal, you'll be notified in writing and a decision date will be set.

If you disagree with Basic Health's decision on your appeal, you may request a further review of that decision verbally or by writing to: Basic Health Appeals, PO Box 42690, Olympia, WA 98504-2690. Basic Health must receive your request for review within 30 days of the date on the notice of Basic Health's appeal decision. You should explain that you are asking for a review of Basic Health's appeal decision. You will be required to provide additional written evidence to show why you believe the appeal decision was incorrect. Also provide a summary of the decision you are contesting, why you believe the decision was incorrect, and a daytime phone number where we can reach you. In addition, the request must include all evidence that has not yet been provided and on which you will rely to explain why you believe Basic Health acted incorrectly. If your request for a review is not received within 30 days of the notice of the appeal decision, you will lose your right for a review.

The Office of Administrative Hearings will review Basic Health's appeal decisions regarding disenrollment due to nonpayment. A presiding officer appointed by the Administrator of the Health Care Authority will review Basic Health's appeal decisions on all other issues, based on the record of the appeal and any evidence you send. Be sure to include all information you want considered. The presiding officer may contact you for further information, but you generally will not be offered an opportunity to explain in person or by phone at this point in the process. The HCA will notify you in writing of the final decision.

You may choose someone, including an attorney or provider, to serve as your personal representative to act on your behalf for the appeal. Basic Health must receive written consent from you allowing this person to represent you before the person can act on your behalf. Contact Basic Health for additional information.

Chapter Seven:
Health Plans and Providers

How the health plans work

All the health plans offer the same basic benefits and require you to choose a primary care provider (PCP) to coordinate or provide your care. Costs, providers and facilities, covered prescription drugs, referral practices, and other things may differ by health plan.

Each health plan contracts with a number of providers and facilities (called the health plan's "provider network"). Your health plan may refer you to a specialist or facility outside the health plan's network if you or your child needs a provider or hospital not available inside your health plan's network. You must get your health plan's approval to be treated by a provider or facility not available through your health plan's provider network, except in an emergency (see page 23).

Some health plans may contract with provider groups called subnetworks; **this may restrict your choice of providers.** You may be required to see specialists or use facilities, such as hospitals, in the same subnetwork as your PCP. This means that even if a provider is in your health plan's provider network, his or her services may not be available to you unless (s)he is also in the same subnetwork as your PCP.

Call the health plan or your PCP to find out if your PCP can refer you to a provider with that health plan's provider network, or if your PCP can refer you to only a selected group of providers within the health plan.

I.D. cards

After you enroll in Basic Health, the health plan will send I.D. cards to you and your enrolled family members. Some health plans may require you to choose a PCP before they issue your I.D. card. The card has important information, including the number to call if you are hospitalized or have questions. If you need care before you receive the card, contact the health plan at the number listed on the inside front cover of this handbook. Your enrollment confirmation letter from Basic Health can serve as temporary identification until you receive your card.

The right to object to certain services

Religiously sponsored health plans, health care providers, or employers have the right to not provide benefits or services for termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your health plan or employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another provider, with no added cost to you. Contact your health plan for more information.

If you object to having coverage for termination of pregnancy or other services, you may notify Basic Health in writing. Benefits will not be provided to you for those services; however, your premium will not change.

Primary care provider (PCP)

Each covered family member must enroll in the same health plan, but may choose a different PCP within that health plan. Except in an emergency, your PCP and staff will provide or coordinate all your health care, including referrals to specialists. Primary care providers may be family or general practitioners, internists, pediatricians, or other providers approved by your health plan. You may change your PCP during the year. Contact your health plan for details on changing providers or for a current list of providers. You may also contact a provider you're considering and ask if (s)he contracts with your health plan for Basic Health coverage. When you call a provider, be sure to mention the health plan name and Basic Health, and ask whether the provider is accepting new patients.

To be covered by your health plan, your PCP must provide all health care services, unless:

- You are referred to another provider by your PCP (in most cases, the referral must be approved by your health plan);
- You need emergency care, as described on page 23; or
- You self-refer for women's health care services (see below) or covered chiropractic care to a provider who contracts with your health plan.

If you have questions, call your health plan at the number listed on the inside front cover of this handbook.

Women's health care services

The following women's health care services are covered by Basic Health without a PCP referral or health plan preauthorization:

- Maternity care, including prenatal, delivery, and postnatal care.
- Routine gynecological exams.
- Examination and treatment of disorders of the female reproductive system, except as specifically excluded.
- Other health problems discovered and treated during the course of a woman's health care visit, as long as the treatment is within the provider's scope of practice, and the service provided is not excluded.

You may seek these services from any women's health care provider who contracts with your health plan. Services provided by hospitals or outpatient surgical centers may require preauthorization from your health plan. Also, any follow-up services for conditions not directly related to maternity care, routine gynecological exams, or disorders of the female reproductive system may require referral and preauthorization by your health plan.

Chapter Eight:
Covered Services and Member Costs

The list of services covered under Basic Health, called the "Schedule of Benefits," is in Appendix A of this handbook. If you have questions about a particular medical condition or Basic Health benefit, contact your health plan directly at the number listed on the inside front cover of this handbook.

Emergency care

Emergency care is covered 24 hours a day, seven days a week. (See page 45 for the definition of "emergency.") To receive emergency care benefits, it is important to follow these steps:

- **Depending on how serious the problem is, go directly to the nearest emergency room, call 911, or call your PCP.**
- **If you are admitted to a hospital or other health care facility, call (or have a friend, family member, or staff member call) your health plan or PCP within 24 hours or as soon as is reasonably possible.**
- **See (or be referred by) your PCP for follow-up care.**

Important: If you do not follow these instructions, and the provider bills for a higher amount than your health plan would pay a contracted provider, you may be required to pay the balance. If the case is determined not to be an emergency (whether or not you follow the instructions), you will be responsible for all costs.

Preexisting condition waiting period

Generally, you must wait nine months from the day your coverage begins before Basic Health will cover preexisting conditions, except for maternity care and prescription drugs. For more information, see "Limitations and exclusions" on page 36.

A preexisting condition is defined as an illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member;
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

If you were enrolled in health care coverage that was similar to Basic Health at any time during the three months just before you applied for or were enrolled in Basic Health, your waiting period for treatment of a preexisting condition may be waived or shortened as described in "Limitations and exclusions" beginning on page 36.

If you had to wait for Basic Health coverage because the program was full, you may receive up to three months' credit toward the waiting period. (This does not apply to the waiting period for organ transplant services.)

Organ transplants

You must be a Basic Health member for 12 months in a row before an organ transplant for a preexisting condition will be covered. See pages 30–31 for details.

Maternity care

If you or an enrolled family member becomes pregnant, call 1-800-660-9840 right away. We will mail a *Maternity Benefits Application* for you to complete and return to us.

Basic Health only covers maternity services for 30 days after pregnancy is confirmed by a medical

provider, unless you apply for the Maternity Benefits Program. The Maternity Benefits Program is run by DSHS and Basic Health. It provides full maternity coverage and allows you to receive care through the same health plan you choose for your Basic Health coverage. When choosing a provider for your maternity care, make sure he or she contracts with your chosen health plan to provide Maternity Benefits Program services through Basic Health.

The Maternity Benefits Program includes the following benefits **at no cost** during pregnancy and for two months after your pregnancy ends:

- Prenatal care
- Maternity support services
- Dental care
- Labor and delivery
- Family planning
- Physical therapy
- Postpartum care
- Transportation to appointments
- Hearing
- Childbirth education
- Maternity case management
- Vision (eye exams and glasses)

DSHS determines eligibility for the Maternity Benefits Program based on their eligibility criteria. Information about this program is available in a separate booklet called *A Guide to Basic Health Plus and the Maternity Benefits Program*. This document will be sent to you when you enroll in the Maternity Benefits Program.

You will need to continue paying your Basic Health premiums until the effective date of your enrollment in the Maternity Benefits Program. Once you are enrolled in the Maternity Benefits Program, you will not have monthly premiums or copayments, and you will continue to receive your care from the health plan you chose through Basic Health. You still must pay the monthly premiums for any family members enrolled in Basic Health.

If you do not meet citizenship requirements for the Maternity Benefits Program, you may be eligible for other DSHS programs that cover maternity care.

To receive these benefits, you must report your pregnancy to Basic Health.

If you do not apply for the Maternity Benefits Program, Basic Health will not cover the cost of any maternity services beyond 30 days after pregnancy is confirmed by a medical provider.

Maternity services will be covered by Basic Health if DSHS finds you ineligible for maternity coverage. Refer to Appendix A for information on maternity coverage for those who are ineligible for the Maternity Benefits Program.

For some Maternity Benefits Program services, such as dental and vision care, the state pays the provider directly.

When your pregnancy ends

You must notify Basic Health at 1-800-660-9840 as soon as your pregnancy ends. An application to add your newborn child to your Basic Health account will be mailed to you. To avoid a break in coverage, Basic Health must receive your completed application to add your newborn within 60 days of the child's birth.

Your Basic Health medical coverage will resume when your maternity benefits end **only if** your family's Basic Health premiums (if any) have been paid while you were enrolled in the Maternity Benefits Program. For example, if you have a spouse and/or dependent(s) enrolled in Basic Health and they are disenrolled for nonpayment while you are covered through the Maternity Benefits Program, your coverage will continue until two months after your pregnancy ends. At that point, you will lose your coverage, and you and your family (except for children enrolled in Basic Health *Plus*) will not be able to reenroll in Basic Health for 12 months. In addition, if Basic Health is full at that time, you will have to wait until space is available.

If the pregnant family member is a child enrolled in Basic Health *Plus*, she does not need to apply for the Maternity Benefits Program, although you must notify Basic Health of the pregnancy. Her maternity benefits will be covered through Basic Health *Plus*. You must notify Basic Health within 60 days of the end of her pregnancy by completing and returning the *Family Changes Form* or the *Change Form*

included with your billing statement to continue the newborn's coverage. To continue coverage for her newborn, your daughter may also need to enroll on her own account.

Member costs

Each member enrolled in Basic Health is responsible for sharing the cost of his or her health care coverage, as follows:

Copayment – A set dollar amount you pay when receiving specific services. In most cases, this will be $15, except for prescription drugs and emergency room visits.

Deductible – The amount you pay before your health plan starts to pay for covered services. You are responsible for paying the first $150 of certain covered medical costs before your health plan pays the 80% coinsurance. The $150 deductible has to be met every calendar year for each family member enrolled in Basic Health. **Your deductible does not apply towards your out-of-pocket maximum.** You may receive a bill from your health plan and/or provider.

Coinsurance – For certain services, you will be responsible for paying 20% of the cost. Your health plan pays the remaining 80%. You may receive a bill from your health plan and/or provider.

Out-of-pocket maximum – Your coinsurance costs apply toward your out-of-pocket maximum of $1,500 per person, per calendar year. When you reach your out-of-pocket maximum, you do not have to pay any further coinsurance costs for covered benefits and services received during that year. Your health plan will pay 100% of the coinsurance for all covered benefits and services. The $1,500 out-of-pocket maximum applies to each family member enrolled in Basic Health.

If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

See the "Schedule of Benefits" on page 27.

If you receive a bill for covered services

If you receive care from a provider who contracts with your health plan, the provider will usually bill the health plan directly.

You will receive a bill from a provider who has provided services to you that require a deductible and coinsurance. In most cases, your health plan will first send you an Explanation of Benefits (EOB) that will explain what service you received, what the allowed amount is for that service, what the health plan has paid, and what you have to pay. The EOB will also provide you with information about how much you have paid toward your deductible and out-of-pocket maximum. The provider or facility where you have received services will then send you a bill. You must pay the provider or facility directly. If you receive a bill but have not yet received an EOB, or if you have questions about your bill, contact the provider's office or your health plan.

In some cases, you may receive a bill from a provider or a facility that does not contract with your health plan, or from a provider who did not know about your Basic Health coverage. (When you fill out information for your provider, be sure to list the health plan that provides your coverage—not Basic Health.) If you receive a bill for services that you think are covered by Basic Health but that have not yet been billed to your health plan, send the bill directly to your health plan at the address on your I.D. card. (Call your health plan at the number listed on the inside cover of this book for details.) Benefits may be denied if your health plan receives the bill more than 12 months after the date you received services.

If a third party is responsible for your injury or illness

You or your representative are required to notify your health plan if your provider charges the health plan for treatment of an injury or illness that is the result of another person's or organization's action or failure to act (for example, a fall, an auto accident, or an accident at work). The other person or organization responsible for your injury or illness is called the "third party."

You must notify your health plan promptly, in writing, of all of the following:

- The facts of the injury or illness, including the name and address of any third party you think may be responsible for the injury or illness;
- The name and address of the third party's insurance company;
- The name and address of any attorneys who will be representing the third party;
- If you plan to file a claim or lawsuit against the third party, the name and address of the person who will be representing you;
- Adequate advance notice of any trial, hearing, or possible settlement of your claim against the third party;
- Any changes in your condition or injury; and
- Any additional information reasonably requested by the health plan.

If you bring a claim or legal action against a liable third party, you must seek recovery of the benefits paid by your health plan.

After you have been fully compensated for all damages you experienced as a result of the accident, your health plan has a right to reimbursement up to the amount of the benefits the health plan has paid, from any recovery you receive. You are required to pay the health plan only the amount that is left over after you have been fully compensated for all of your damages (including pain and suffering and lost wages), up to the amount of the benefits paid.

If your health plan seeks to recover benefits directly from the third party, you must cooperate fully and not do anything to impair your health plan's right of recovery. Your health plan may bring suit against the third party in your name, or may join as a party in a lawsuit or claim you have filed. Your health plan will not be required to pay for legal costs you incur, and you will not be required to pay legal costs incurred by your health plan. However, your health plan may agree to share the cost if they choose to be represented by your attorney.

You could be disenrolled from Basic Health for intentional misconduct if you:

- Withhold from your health plan information you have about a legally responsible third party; or
- Refuse to help your health plan collect from that legally responsible third party.

Appendix A:
Schedule of Benefits

This "Schedule of Benefits" lists benefits for Basic Health members. Services are subject to all provisions of this "Schedule of Benefits," including limitations, exclusions, deductibles, coinsurance, and copayments. Except as specifically stated otherwise, all services and benefits under Basic Health must be provided, ordered, or authorized by the health plan or its contracting providers. Even if your provider authorizes a service, your health plan may also need to preauthorize the care.

Services in addition to those listed in this "Schedule of Benefits" may be provided at the sole discretion of the health plan through the health plan's medical management or case management program if providing the service will result in a lower total out-of-pocket cost to the health plan. Additional services may be subject to copayments, deductibles, coinsurance, and limitations. As an example, oxygen or enteral and parenteral nutrition may be covered as benefit exceptions for individuals who would otherwise require hospitalization, or for services which would result in a lower out-of-pocket cost to the health plan as determined by the health plan.

If you have a question about the benefits listed, or are not sure if a service is covered, you should call the health plan's customer service department.

I. Medically necessary services, supplies, or interventions

Basic Health provides coverage for services, supplies, or interventions that are otherwise included as a "covered service," as set forth in Section II, that are not excluded and are medically necessary. A covered service is "medically necessary" if it is recommended by your treating provider and your health plan's medical director or provider designee, and if all of the following conditions are met:

A. The purpose of the service, supply, or intervention is to treat a medical condition;

B. It is the most appropriate level of service, supply, or intervention considering the potential benefits and harm to the patient;

C. The level of service, supply, or intervention is known to be effective in improving health outcomes;

D. The level of service, supply, or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and

E. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

A health "intervention" is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation), or to maintain or restore functional ability. For purposes of this definition of "medical necessity," a health intervention means not only the intervention itself, but also the medical condition and patient indications for which it is being applied.

"Effective" means that the intervention, supply, or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

An intervention, supply, or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "medical necessity." Your health plan may choose to cover interventions, supplies, or services that do not meet this definition of "medical necessity;" however, the health plan is not required to do so.

"Treating provider" means a health care provider who has personally evaluated the patient.

"Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.

"New interventions" for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (see "existing interventions" below).

"Scientific evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

For "existing interventions," the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of "medical necessity." If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the Basic Health definition of "medical necessity" in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

A level of service, supply, or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

II. Covered services

The following services are covered when they are medically necessary. All services, supplies, and interventions are subject to the appropriate copayment, deductible, and coinsurance. (See Section III. Copayments, deductibles, and coinsurance.)

A. Hospital care

The following hospital services are covered:

1. Semi-private room and board, including meals; private room and special diets; and general nursing services.
2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room when eligible for Basic Health maternity benefits, anesthesia, radiology, laboratory, and other diagnostic services.
3. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, nursery and laboratory services.
4. Drugs and medications administered while an inpatient.
5. Special duty nursing.

6. Dressings, casts, equipment, oxygen services, and radiation and inhalation therapy.

If a member is hospitalized in a non-contracting facility, the health plan has the right to require transfer of the member to a contracting health plan facility at the health plan's expense, when the member's condition is sufficiently stable to enable safe transfer.

If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Personal comfort items such as telephone, guest trays, and television are not covered.

B. Medical and surgical care

The following medical and surgical services are covered. The health plan may require that certain medical and surgical services be provided on an outpatient basis.

1. Surgical services.
2. Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.
3. Dressings, casts, and use of cast room; anesthesia and anesthesia-related oxygen services.
4. Blood, blood components, and fractions (such as plasma, platelets, packed cells, and albumin), and their administration.
5. Provider visits, including diagnosis and treatment in the hospital, outpatient facility, or office; consultations, treatment, and second opinions by the member's PCP, or by a referral provider. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, routine newborn exams and laboratory services.

   Pharmaceuticals that are or would normally be an intrinsic part of a provider visit (inpatient or outpatient) are covered as part of the provider visit.
6. Radiation therapy; chemotherapy.
7. Inpatient and outpatient chiropractic and physical therapy services are covered to a combined maximum of six visits per calendar year, and are covered for only post-operative treatment of reconstructive joint surgery when received within one year following surgery. Diagnostic or other imaging procedures solely for determination of therapy services are not covered. Covered chiropractic services may be referred or self-referred to contracted providers.
8. Prescription drugs and medications as defined in "Pharmacy benefit."
9. Family planning services provided by the member's PCP or women's health care provider. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps, and long-acting progestational agents) determined most appropriate by the PCP or women's health care provider for use by the member are also covered. Over-the-counter supplies such as condoms and spermicides are covered only when part of a health plan protocol at the health plan's discretion. Elective sterilization is covered.

C. Maternity care

For pregnant Basic Health members who are determined to be eligible for medical assistance through the Department of Social and Health Services (DSHS), Basic Health only covers maternity care services for a period not to exceed 30 days following diagnosis of pregnancy.

The following maternity care services are covered for members who are determined to be ineligible for medical assistance through DSHS: diagnosis of pregnancy; full prenatal care after pregnancy is confirmed; delivery; postpartum care; care for complications of pregnancy; preventive care; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; medications; anesthesia; normal newborn care following birth, such as, but not limited to,

nursery services and pediatric exams; and termination of pregnancy (including voluntary termination of pregnancy).

D. Chemical dependency

Members are eligible to receive residential and outpatient chemical dependency treatment from a health plan-contracting approved treatment program to a maximum benefit of $5,000 in a 24 consecutive calendar month period up to a lifetime benefit maximum of $10,000. Covered residential and outpatient treatment includes services such as diagnostic evaluation and education, and organized individual and group counseling. The hospital inpatient deductible and coinsurance applies to intensive inpatient services. Health plans may use lower copayments, if applicable, for group sessions.

(**NOTE:** Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity.")

In determining the $5,000 limit, the health plan reserves the right to take credit for chemical dependency benefits paid by any other group medical plan on behalf of a member during the immediate preceding 24 consecutive calendar month period. In determining the $10,000 lifetime limit, the health plan reserves the right to take credit for chemical dependency benefits paid under Basic Health on behalf of the member from January 1, 1988.

E. Mental health services

Mental health services are covered as follows:

Inpatient care in a participating hospital or other appropriate licensed facility approved by the health plan is covered in full (subject to deductible and coinsurance) up to 10 days per calendar year.

Outpatient care, including individual and family counseling, is covered in full up to 12 visits per calendar year after the copayment per visit for individual sessions. Health plans may use lower copayments, if applicable, for group sessions. Visits for the sole purpose of medication management are exempted from the 12-visit limit, and are instead covered as other provider visits.

(**NOTE:** Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity.")

F. Organ transplants

Services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care, are covered. Deductible, coinsurance, and copayments apply by specific service. (See Section III. Copayments, deductible, and coinsurance.) This benefit includes covered donor expenses.

Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, cornea, kidney, and kidney-pancreas human organ transplants are covered when the Basic Health definition of "Medical Necessity" is met.

Organ transplant recipient: All services and supplies related to the organ transplant for the member receiving the organ, including transportation to and from a health plan-designated facility (beyond that distance the member would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the member has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ transplant donor: The donor's initial medical expenses relating to harvesting of the organ(s), as well as the costs of treating complications directly resulting from the procedure(s), are covered, **provided the organ recipient is a member of the health plan**, and provided the donor is not eligible for such coverage under any other health care plan or government-funded program.

Waiting period: Members must be enrolled in Basic Health for 12 consecutive months before they are eligible to receive benefits for covered transplant procedures. The waiting period applies to the transplant procedure including any immediate pre- and post-operative hospital care related to the transplantation, but does not apply to ongoing follow-up care including prescription drugs.

If a member satisfies the 12 consecutive months' waiting period (no breaks in coverage for 12 consecutive months) and subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

The waiting period will not apply:

1. If the transplant is required due to a condition which is not a preexisting condition;
2. For children enrolled in and continuously covered by Basic Health from birth; or
3. For children placed in the home for purposes of adoption within 60 days of birth and continuously covered by Basic Health from the date of placement, provided one or both of the adoptive parents or family members are enrolled in Basic Health at the time of placement in the home.

If a newborn child enrolled from birth, or a newborn-adoptive child enrolled within 60 days of placement, subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

Limitations: Transplants that are not preauthorized or are not performed in a health plan-designated medical facility are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

All services are subject to the appropriate copayment, deductible, and coinsurance.

G. Emergency care

An emergency is a sudden or severe health problem that needs treatment right away; there is not time to talk to your doctor.

"Emergency" is defined as:

> "The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy."

The health plan reserves the right to determine whether the symptoms indicate a medical emergency. Acute detoxification is covered for up to 72 hours.

1. **In-service-area emergency.** In the event a member experiences a medical emergency, care should be obtained from a health plan-contracting provider. If, as a result of such emergency, the member is not able to use a health plan-contracting provider, the member may obtain emergency services from non-contracting health care providers. Follow-up care must be provided or approved by the health plan in advance. In the case of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If you fail to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.

2. **Out-of-service-area emergency.** The health plan shall bear the cost of out-of-service-area emergency care for covered conditions. In the event of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If you fail to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider, had notification requirements been met. The member will be financially responsible for any remaining balance.

   The health plan may, at its discretion, appoint a consultant when out-of-service-area care is necessary, who will have authority to monitor the care rendered and make recommendations regarding the treatment plan. The health plan may otherwise secure information which it deems necessary concerning the medical care and hospitalization provided to the member for which payment is requested.

3. **Transfer and follow-up care.** If a member is hospitalized in a non-contracting facility, the health plan reserves the right to require transfer of the member to a health plan-contracting facility, when the member's condition is sufficiently stable to enable safe transfer. If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

   Follow-up care that is a direct result of the emergency must be obtained from a health plan-contracting provider, unless a health plan-contracting provider has authorized you to continue to receive follow-up care from another provider in advance.

4. **Prescription drugs.** Prescription drugs purchased from a non-contracting facility or pharmacy are covered subject to the applicable pharmacy copayment when dispensed or prescribed in connection with covered emergency treatment.

5. **Emergency ambulance transportation.** Medically necessary ambulance transportation is covered in an emergency, or to transfer a member when preauthorized by the health plan.

H. Skilled nursing and home health care benefits

As an alternative to hospitalization in an acute care facility, the health plan, at its discretion, may authorize benefits for the services of a skilled nursing facility or home health care agency.

I. Hospice services

Hospice services are covered.

J. Plastic and reconstructive services

Plastic and reconstructive services (including implants) will be provided only under the following conditions:

1. To correct a physical functional disorder resulting from a congenital disease or anomaly;
2. To correct a physical functional disorder following an injury or incidental to covered surgery; and
3. For a member who is receiving benefits in connection with a mastectomy:
   a. Reconstruction of the breast on which the mastectomy was performed;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. Prostheses (internal and external) and physical complications of all stages of mastectomy.

   Treatment of lymphedemas is covered; however, durable medical equipment and supplies used to treat lymphedemas may be covered only in limited circumstances. Please contact your health plan for specific coverage information.

K. Preventive care

Preventive care services are covered, and will be provided as described in the schedule provided to you by the health plan.

L. Pharmacy benefit

The health plan may limit the drugs covered through use of a list called a "formulary." Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determines that no formulary drugs are an acceptable medication for the patient. If you have a question about the pharmacy benefit, are not sure if a drug is covered, or believe a nonformulary drug should be covered, you should call the health plan's customer service department for information.

Basic Health covers drugs (of all types, including prescribed creams, ointments, and injections) at the copayment levels shown. Prescriptions are not subject to the deductible and will not apply towards the annual out-of-pocket maximum.

Prescriptions are limited to a 30-day supply.

Drugs for cosmetic purposes are excluded unless preauthorized.

(See table below for more pharmacy copayment information.)

Tier 1 – Copayment: $10	Tier 2– Copayment: 50%
Covered drugs:	**Covered drugs:**
Generic drugs contained in the health plan's formulary. All oral contraceptives in the health plan's formulary. Diabetic supplies, including syringes and needles, diabetic test strips, lancets, and insulin.	Brand-name drugs in the health plan's formulary.

III. Copayments, deductibles, and coinsurance

Each member is responsible for paying a $150 deductible per calendar year before some benefits and services will be covered (see following page). For those services with a coinsurance, once the deductible has been met, the health plan pays 80% of allowed charges and the member pays 20% of allowed charges. All coinsurance payments will be applied towards the annual out-of-pocket maximum. For each member the out-of-pocket maximum is $1,500 per calendar year. No amount paid toward the $150 deductible will be applied towards the out-of-pocket maximum. Once the out-of-pocket maximum has been reached, the health plan pays 100% towards all covered benefits and services with a coinsurance.

The member is responsible for paying any required copayment, deductible and/or coinsurance directly to the provider of a covered service unless instructed by the health plan to make payment to another party. Copayments, deductibles, and coinsurance payments must be paid in full, or service may be denied or rescheduled.

Only the cost sharing specifically listed in the following tables will be charged to members for covered services. Members may be charged a missed appointment fee by a provider if they continually fail to keep appointments, or if they repeatedly fail to give timely notice when it is necessary to cancel appointments.

Benefits and services NOT subject to the deductible and coinsurance

The $150 annual deductible and $1,500 out-of-pocket maximum per person, per calendar year do not apply to the following benefits and services.

Benefit/service	Member's payment responsibility	Notes
Preventive care	No copay	Includes routine physicals, immunizations, PAP tests, mammograms, and other screening and testing when provided as part of the preventive care visit.
Office visits	$15 copay	Copay is for office visit only and includes consultations, mental health and chemical dependency outpatient visits, office-based surgeries, and follow-up visits. Copays do not apply to preventive care, laboratory, radiology services, radiation, and chemotherapy. Some services will be subject to coinsurance.
Pharmacy*		30-day supply
Tier 1	$10 copay	Tier 1 includes generic drugs in health plan's preferred drug list (formulary); diabetic supplies, including syringes and needles, diabetic test strips, lancets, and insulin; and all oral contraceptives in health plan's formulary.
Tier 2	50% of the drug cost	Tier 2 includes brand-name drugs in health plan's preferred drug list (formulary).
Emergency room visit	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Out-of-area emergency services	$100 copay	No copay if admitted; hospital coinsurance and deductible would apply.
Urgent care	$15 copay	Copay is for office visit only, when provided in an urgent care setting. Deductible and coinsurance may apply to other services.
Skilled nursing, hospice, and home care	No copay	Covered as an alternative to hospital care at the health plan's discretion.
Maternity care	No copay	If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services.

* Different health plans have different lists of approved prescription drugs (formularies). To find out if a specific drug is covered in your pharmacy benefit, contact your health plan.

Benefits and services subject to the deductible and coinsurance

Before your health plan pays the 80% coinsurance for the following benefits, you must first pay your $150 annual deductible. Once you meet your $150 deductible, all coinsurance payments will be applied toward your $1,500 annual out-of-pocket maximum. Deductibles and out-of-pocket maximums are per person, per year. Once the $1,500 per person out-of-pocket maximum has been reached, the health plan pays for all covered benefits and services with a coinsurance. Members are only responsible for copays for benefits and services listed on page 34. If you change health plans any time during the year, the amount you've paid toward your deductible and out-of-pocket maximum for covered family members will start over with your new health plan.

Benefit/service	Member's payment responsibility	Notes
Hospital, inpatient	20% coinsurance; deductible applies. $300 maximum facility charge per admittance.	Facility charges may include, but are not limited to, room and board, prescription drugs provided while an inpatient, and other services received as an inpatient. No charges for maternity care or when readmitted for the same condition within 90 days. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered through the Department of Social and Health Services. See "Other professional services" below.
Hospital, outpatient	20% coinsurance; deductible applies	
Other professional services	20% coinsurance; deductible applies	Includes services received as an inpatient including, but not limited to, surgeries, anesthesia, chemotherapy, radiation, and other types of inpatient and outpatient services.
Mental health	20% coinsurance; deductible applies to inpatient. $300 maximum facility charge per admittance.	Limited to 10 inpatient days a year and 12 outpatient visits a year. Office visits to manage medication do not count towards 12-visit maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Laboratory	No copay or coinsurance for outpatient services. 20% coinsurance for inpatient hospital-based laboratory services.	Deductible applies to services with coinsurance.
Radiology	20% coinsurance, except for outpatient x-ray and ultrasound.	Deductible applies to services with coinsurance.
Ambulance services	20% coinsurance; deductible applies	Includes approved transfers from one facility to another. No coinsurance if transfer is required by the health plan.
Chiropractic/ physical therapy	20% coinsurance; deductible applies	Up to six visits combined for postoperative treatment following reconstructive joint surgery, as long as visits are within one year of surgery.
Chemical dependency	20% coinsurance and deductible apply to inpatient. $300 maximum facility charge per admittance.	Limited to $5,000 every 24-month period; $10,000 lifetime maximum. Outpatient visits are subject to $15 copay (see "Office visits").
Organ transplants	Deductible, coinsurance, and copays apply by specific service.	12-month waiting period, except for newborns or for a condition that is not preexisting.

IV. Limitations and exclusions

A. Limitations

1. **Preexisting condition waiting period**

   a. **A preexisting condition is defined as:** "Any illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

   (1) Treatment, consultation, or a diagnostic test was recommended for or received by the member; or

   (2) Medication was prescribed or recommended for the member; or

   (3) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment."

   b. **Waiting period**

   Basic Health will not provide benefits for services or supplies rendered for any preexisting condition during the first nine consecutive months following the member's effective date of coverage. A member will not be required to begin a new nine consecutive-month waiting period if:

   (1) Coverage is suspended for not longer than one month during the waiting period, and

   (2) The member does not have more than two (2) one-month breaks in coverage during the waiting period.

   Coverage for preexisting conditions will not be available until the member is actually covered by Basic Health for a total of nine months.

   If the member is confined in a health care facility for treatment of a preexisting condition at the time the member's nine-month waiting period ends, benefits for that condition will be provided only for covered services rendered after the end of the waiting period.

   c. **Exceptions to waiting period**

   (1) The following services are not subject to the waiting period:

   - Maternity care.
   - Prescription drugs as defined in "Pharmacy Benefit."

   (2) Children born on or after the parent's or sibling's effective date of coverage who are enrolled within 60 days of the date of birth, and adopted children who are placed for adoption after the adoptive parent's or sibling's effective date of coverage who are enrolled within 60 days of placement with the adoptive parents, are not subject to the nine-month waiting period for preexisting conditions.

   d. **Credit toward the waiting period**

   Credit toward the waiting period will be given:

   (1) If Basic Health delays your enrollment (up to a maximum of three months) due to budgetary constraints, and you have been determined eligible.

   (2) For any continuous period of time during which a member was covered under similar health coverage if:

   - That coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under Basic Health, or within the three-month period immediately preceding enrollment in Basic Health; and
   - The coverage terminated not later than the first of the month following the effective date of coverage in Basic Health.

If similar coverage was in effect both prior to the date of application or reservation and the date of enrollment, credit will be given for the longer period of continuous coverage.

"Similar coverage" includes Basic Health, all DSHS programs which have the Medicaid scope of benefits, the DSHS program for the medically indigent, Indian Health Services, most coverages offered by health carriers, and most self-insured plans.

2. **Major Disaster or Epidemic**

   If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of a major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.

3. **Coordination of Benefits**

   The benefits available under Basic Health shall be secondary to the benefits payable under the terms of any health plan, which provides benefits for a Basic Health member except where in conflict with Washington State or federal law.

B. Exclusions

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of "Medical Necessity" for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.
3. Services received before the member's effective date of coverage.
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.
6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Transportation except as specified under "Organ transplants" and "Emergency care."
9. Immunizations, except as covered under preventive care. Immunizations for the purpose of travel, employment, or required because of where you reside are not covered.
10. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.
11. Sex change operations.
12. Investigation of or treatment for infertility or impotence.

13. Reversal of sterilization.
14. Artificial insemination.
15. In-vitro fertilization.
16. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care."
17. Hearing aids.
18. Orthopedic shoes and routine foot care.
19. Speech, occupational, and recreation therapy.
20. Medical equipment and supplies not specifically listed in this "Schedule of Benefits" except while the member is in the hospital (including, but not limited to, hospital beds, wheelchairs, and walk aids).
21. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
22. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity, including morbid obesity (such as, but not limited to, gastroplasty, gastric stapling, or intestinal bypass).
23. Weight loss programs.
24. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."
25. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
26. Conditions resulting from acts of war (declared or not).
27. Direct complications arising from excluded services.
28. Replacement of lost or stolen medications.
29. Evaluation and treatment of learning disabilities, including dyslexia.
30. Any service or supply not specifically listed as a covered service unless medically necessary, prescribed by a contracting provider, and authorized in advance by the health plan.

C. Changes to covered services and premiums

Basic Health may from time to time revise this "Schedule of Benefits." In designing and revising this "Schedule of Benefits," Basic Health will consider the effects of particular benefits, copayments, deductibles, coinsurance, out-of-pocket maximums, limitations, and exclusions on access to medically necessary basic health care services, as well as the cost to members and to the state. Generally accepted practices of the health insurance and managed health care industries will also be taken into account.

Basic Health will provide you with written notice of any planned revisions to your Basic Health premiums or the benefit plan at least 30 days prior to the effective date of the change. This notice

may be included with your premium statement, open enrollment materials or other mailing, or may be a separate notice. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first-class postage paid, directed to you at the mailing address you provided to Basic Health.

Appendix B:
Health Coverage Tax Credit (HCTC) – Basic Health

Program overview

The Health Coverage Tax Credit (HCTC) is a federal income tax credit that pays 65 percent of the health plan premium for eligible people enrolled in "qualified health plans." In Washington State, Basic Health is a qualified health plan. However, in Basic Health materials, "health plan" refers to the company that provides your health care coverage (Columbia United Providers, Community Health Plan of Washington, Group Health Cooperative, Kaiser Foundation Health Plan of the Northwest, or Molina Healthcare of Washington). For information on other qualified plans in Washington, call the HCTC Customer Contact Center or visit the Internal Revenue Service (IRS) Web site (see "HCTC contact information" on page i).

Eligibility

To be eligible for the HCTC, you do not need to be eligible for Basic Health. You may be eligible if you are a displaced worker, enroll in a qualified health plan (such as Basic Health), and:

- Receive Trade Readjustment Allowance (TRA) under the Trade Adjustment Assistance (TAA) Act or Alternative Trade Adjustment Assistance (ATAA);
- Would be eligible to receive TRA but have not yet used all of your unemployment insurance benefits; or
- Are age 55 or over, receive pension benefits from the Pension Benefits Guaranty Corporation, and are not entitled to Medicare Part A.

To find out if you are eligible or to register for the tax credit, contact the HCTC Customer Contact Center or visit the HCTC Web site (see "HCTC contact information" on page i).

Premiums

If you are eligible for the HCTC, you may claim it as an advance credit to help pay your premiums, or you may claim it when you file your federal income tax return. Either way, the tax credit will pay 65 percent of your HCTC-Basic Health premium. You pay the other 35 percent.

HCTC-Basic Health members are billed the full cost of their coverage, plus an administrative fee. Premiums are adjusted according to age, choice of health plan, and the county where services are provided. If you are claiming the HCTC advance tax credit for your Basic Health enrollment, you will receive a monthly invoice from the IRS. You will pay the IRS your share of the premium each month, and the IRS will pay Basic Health for your coverage. **If you do not pay your share of the premium to the IRS on time, the IRS will not pay your premium and you will lose coverage for one month.** You may be able to continue your coverage by paying the full premium directly to Basic Health for up to two months or applying for subsidized Basic Health coverage. Basic Health cannot accept your direct payment prior to enrolling in HCTC-Basic Health.

Making changes

HCTC-Basic Health members must report family changes, address changes, and changes in their HCTC eligibility to Basic Health. If you ask to have members added or removed from your account, Basic Health will send you a premium change notice; you must forward that notice to the IRS. To tell us about a change to your account, call 1-800-660-9840, fax a letter to 360-923-2910, or send a letter to HCTC-Basic Health at PO Box 42703, Olympia, WA 98504-2703. Be sure to include your HCTC-Basic Health I.D. number on all correspondence.

If you move and your current health plan is not

available in your new area, you will be required to choose a health plan that serves your new area. Otherwise, you may change health plans only during open enrollment, or when you move and your current health plan will cost more or a health plan is available that was not previously available. An exception may be made in some cases if you can prove that you need to continue a current course of treatment with a specific provider. When you change health plans, remember that each health plan contracts with different providers and has its own list of covered prescription drugs. Call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription medications, you also should contact the health plan to see if your medications will be covered.

If you live outside Washington State, you will be asked to choose a county within Washington where you will receive your medical services. You must choose a health plan within that county. If you move, please call Basic Health at 1-800-660-9840 to discuss whether you will remain with the same health plan and in the same county of service. If you are covering a child who is away from home attending college, that child must also get HCTC-Basic Health services through the health plan and in the Washington State county you have chosen. Only emergency services are covered outside of the health plan's service area.

If you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Also, your deductible and out-of-pocket maximum will start over with the new health plan. Check with your health plan for further information.

Basic Health is committed to making sure your health plan is available throughout the year. However, if your health plan becomes unavailable during the year, you will be able to choose among the other plans in your county. If only one health plan remains, you will be assigned to that plan.

If you want to add or remove a family member to your HCTC-Basic Health account, please call Basic Health. We will send you an updated monthly premium notice that you can forward to the HCTC program. Please note that we will need a signature from anyone age 18 or over who is added to your account. It is important that you contact us before you want a change to be effective. Because premiums for your HCTC-Basic Health coverage are paid for by the IRS, and HCTC-Basic Health cannot cover a family member until the premium is received from the IRS, you should allow plenty of time.

Suspension, disenrollment, and reenrollment

If Basic Health does not receive your premium from the IRS by the first of the month, you will not have coverage for that month. (Any payments you have made toward your deductible and out-of-pocket maximums will remain intact.) In this case, you may pay the full cost of your own coverage. However, because nonpayment from the IRS can mean you are no longer eligible for the program, you will only be able to pay your own premium for two months before you will be disenrolled from HCTC-Basic Health. If you have not already been notified by the IRS of the reason for not paying your HCTC-Basic Health premium, call the HCTC Customer Care Center at 1-866-628-4282.

You may also be disenrolled from HCTC-Basic Health if you:

- Take part in any form of abuse, intentional misconduct, or fraud against Basic Health or your health plan or its providers, or knowingly give information to Basic Health that is false or misleading;
- Intentionally withhold information required by HCTC or Basic Health;
- Pose a risk to the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors;
- Refuse to follow procedures or treatment recommended by your provider and determined by your health plan's medical director to be essential to your health or the health of your child, and you have been told by your health plan that no other treatment is available;
- Repeatedly do not pay copayments, coinsurance, or other payments on time; or

- Withhold from your health plan information you have about a legally responsible third party, or refuse to help your health plan collect from that legally responsible third party.

If you want to disenroll from HCTC-Basic Health, contact Basic Health. However, if you plan to change your HCTC coverage to another qualified health plan, you should contact the HCTC Customer Contact Center first.

Rights, responsibilities, and privacy

All information in Chapter Five (Rights, Responsibilities, and Privacy) applies to HCTC-Basic Health members, except as noted below.

- As an HCTC-Basic Health member, you have the right to file an appeal with your health plan or with the federal HCTC program if you are not satisfied with their decision. You will not have an appeals process with Basic Health unless you have paid 100 percent of your premium for the time in question.
- As an HCTC-Basic Health member, you do not have to provide Basic Health with information about your income.
- As an HCTC-Basic Health member, you are not required to pay your premium directly to Basic Health, unless notified. The IRS will send your monthly premium to Basic Health. You will pay 35 percent of that amount directly to the HCTC program.

HCTC-Basic Health grievances and appeals

If you have a grievance or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find the toll-free numbers on the inside front cover of this book. For more information on grievances with your health plan, read "Grievances against your health plan" on page 19.

If you disagree with a decision that you are not eligible for the HCTC program, contact the HCTC Customer Contact Center.

If you have paid 100 percent of your Basic Health premium, and have a complaint about something Basic Health did during the time you paid your own premium, go to page 20.

Whenever you call any of these organizations, be sure you note the date of the call, the name of the person you talked to, and whether that person was with the HCTC program, your health plan, or Basic Health.

Health plans and providers

All of Chapter Seven applies to HCTC-Basic Health members.

Covered services

Benefits for HCTC-Basic Health members are the same as for all Basic Health members (see page 27), with the following exceptions:

- The nine-month waiting period for treatment of preexisting conditions will be waived if you had at least three months of creditable coverage before enrolling in Basic Health, with no more than a 62-day break in coverage when you applied for HCTC-Basic Health. If you had a break in coverage of 63 days or more at the time of your application to Basic Health, or if you did not have three months of creditable coverage, the nine-month waiting period will apply the same as for all other Basic Health members. For HCTC purposes, creditable coverage includes a group health plan (including COBRA, Temporary Continuation of Coverage [TCC], or state continuation coverage) or health insurance (including individual coverage, college or school insurance, or short-term limited duration insurance).
- HCTC-Basic Health will cover maternity benefits as described on page 29 for members "determined ineligible for medical assistance through DSHS." You will not be required to apply for the Maternity Benefits Program.

Member costs

Each member enrolled in HCTC-Basic Health will share the cost for his or her health care coverage. See the sections "Member costs," "If you receive a bill for

covered services," and "If a third party is responsible for your injury or illness" on pages 25–26 for details.

Continuation rights

If you leave Basic Health and enroll in coverage through an employer or privately purchased health plan in Washington State, the time you were enrolled through the HCTC program may be considered creditable coverage for purposes of shortening or waiving the waiting period for treatment of a preexisting condition. However, unlike COBRA coverage, if you apply for private insurance coverage in Washington State, your HCTC-Basic Health enrollment will not exempt you from the health plan's use of the standard health questionnaire for screening applicants.

Schedule of benefits

The Schedule of Benefits in Appendix A applies to HCTC-Basic Health members, except as noted in "Covered Services" on page 43.

HCTC contact information

Customer Contact Center (toll-free):
1-866-628-4282 (TTY: 1-866-626-4282)

Web site: **www.irs.gov** (IRS keyword: HCTC)

Appendix C:
Definitions of Terms

Appeal

A formal request for the health plan or Basic Health to review its decision.

Basic Health

A health care coverage program administered by the Health Care Authority (HCA).

Basic Health *Plus*

A program jointly administered by the Department of Social and Health Services (DSHS) and Basic Health for children under age 19 from low-income families. It provides expanded benefits (such as dental and vision care). Eligibility for Basic Health *Plus* is determined by DSHS.

Certificate of coverage

A description of your health care coverage and benefits. This handbook serves as your certificate of coverage.

Coinsurance

A percentage you pay for certain services after you have paid your annual deductible.

Copayment or copay

A set dollar amount you pay when you receive specific services. Copays are not subject to a deductible and do not apply toward your deductible, coinsurance, or out-of-pocket maximum.

Department of Social and Health Services (DSHS)

The state agency that administers Medicaid and (along with the Health Care Authority) jointly administers Basic Health *Plus* and the Maternity Benefits Program.

Deductible

The amount you pay before your health plan starts to pay for services with coinsurance. The deductible will not apply toward your out-of-pocket maximum.

Dependents

Same as family members.

Disenrollment

Losing Basic Health coverage without the option of reenrolling the following month. This can be due to nonpayment by the due date given in the suspension notice; more than two suspensions in a 12-month period; loss of eligibility; or for failure to abide by any of your responsibilities as a Basic Health member.

Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Enrollment

The process of submitting completed application forms, being determined eligible, and being accepted into Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.

Explanation of benefits (EOB)

Each health plan is required to send an EOB each time you receive medical services. The EOB is a detailed statement that explains the service(s) you received,

the allowed amount for each service, the amount the health plan pays, and the amount you are responsible to pay. The EOB will also track the amount you have paid towards each covered family member's annual deductible and out-of-pocket maximum.

Family members

Family members who should be listed as dependents on your account (whether or not they are enrolling for coverage) include:

- Your spouse living in the same household and not legally separated from you.
- Your unmarried child, including stepchild, legally adopted child, and a child placed in your home for purposes of adoption or under your legal guardianship who is:
  - Under age 19; or
  - Under age 23 and a full-time student at an accredited school. You are required to send proof from the school each year when your dependent is age 19 through 22, to show that he or she is a full-time student. If your dependent over age 18 is no longer a full-time student, you must notify Basic Health within 30 days of this change.
- Your unmarried child under age 19, enrolling for coverage and in your custody under an informal guardianship agreement that is signed by the child's parent(s) and authorizes you to obtain medical care for the child. To request coverage for a child living with you under such an agreement, you must provide a copy of the guardianship agreement and proof that you are providing at least 50 percent of the child's support. If a child is placed in your home under a foster care agreement, DSHS is generally the guardian, so you will not be allowed to list that child.
- Your unmarried child, stepchild, legally adopted child, or other legal dependent of any age who is incapable of self-support due to disability. You must provide proof of disability. If the dependent with a disability is not your birth or adopted child, you must also provide proof of legal guardianship.

If you are a Health Coverage Tax Credit eligible enrollee, list all dependents that are eligible for coverage through that program.

Family size

The number of family members eligible to be listed on a Basic Health account. Family size is considered when determining eligibility and premiums.

Formulary

A list of approved prescription drugs developed by each health plan.

Grievance

A written or an oral complaint submitted by or on behalf of a covered person to their health plan or Basic Health.

Health Care Authority (HCA)

The state agency responsible for Basic Health administration and coordinating with DSHS to provide Basic Health *Plus* and the Maternity Benefits Program.

Health Coverage Tax Credit eligible member (or HCTC-Basic Health member)

An individual or qualified dependent enrolled in Basic Health and determined by the federal Department of Treasury to be eligible for the tax credit created by the Trade Act of 2002 (P.L. 107-210).

Health plan

An organization that offers health care coverage and contracts with the HCA to provide your care. You choose your health plan when you join Basic Health.

Income

Your and your family's gross income (before deductions).

Income band

Income levels A through H, as listed on page 6. These are updated in July of each year. (Look for a notice of the changes in May.) These levels, based on gross monthly income and family size, help determine monthly premiums.

Income guidelines

The guidelines used to determine your eligibility for Basic Health and Basic Health *Plus*, and your monthly premium payments for Basic Health coverage. These income guidelines change annually. See page 5 for more information.

Inpatient

A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

Maternity Benefits Program

The program coordinated with DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity benefits, maternity support services, and maternity case management. Eligibility for the program is determined by DSHS.

Medicare

The federal health benefit program for people who are age 65 and over, and for some people with disabilities. (If you are eligible for free or purchased Medicare coverage, you are not eligible for Basic Health.)

Member

A person enrolled in and receiving health care coverage through Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.

Non-compliance

Failure to provide documentation or information requested by Basic Health by the due date.

Out-of-pocket maximum

The most coinsurance you will have to pay each year for each covered family member. Only your coinsurance costs apply toward your out-of-pocket maximum. After you have paid the out-of-pocket maximum, you do not have to pay coinsurance costs for the remainder of the calendar year.

Outpatient

A nonhospitalized patient receiving covered services away from a hospital, such as in a physician's office or the patient's own home, or in a hospital outpatient or hospital emergency department or surgical center.

Personal eligibility statement (PES)

The notice Basic Health sends you showing the current status of your account. You will receive a PES when there is a change to your account. This statement may include a bill for additional premiums you must pay as a result of a change.

Preexisting condition

An illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member;
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.

Premium

Your monthly payment for Basic Health coverage.

Primary care provider (PCP)

Your personal health care provider. Your primary care provider can be a family or general practitioner, internist, pediatrician, or other provider approved by your health plan. To receive benefits, your primary care provider must provide or coordinate your care. If you need to see a specialist, your primary care provider will refer you.

Provider

A health care professional (such as a doctor, nurse, internist, etc.) or facility (such as a hospital, clinic, etc.).

Recertification

Periodic review of your family's income and eligibility. During recertification, you are required to submit current income and residency documentation to verify your eligibility and/or level of premium subsidy.

Recoupment

When Basic Health bills you for the amount you owe the state because you did not accurately report your income.

Service area

The geographic area served by a health plan that provides coverage for Basic Health members.

Specialist

A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

Student

A person enrolled full time in an accredited secondary school, college, university, technical college, or school of nursing, as determined by the school registrar.

Subscriber

The person on a Basic Health account who is responsible for payment of premiums and other cost sharing, and to whom Basic Health sends all notices and communications. The subscriber may be a Basic Health member or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage.

Subsidy/subsidized

The portion of the premium that Washington State pays for enrolled Basic Health members.

Suspension of coverage

The process of losing health coverage for one month after a monthly premium has not been paid or has been paid in full after the due date. If your coverage is suspended more than two times in a 12-month period, you will be disenrolled and cannot reenroll for at least 12 months.

Tier

A category of drugs related to the pharmacy benefit. Your cost for prescriptions depends on the category (or tier) the prescription falls within. Tier 1 is the category of prescriptions that costs you the least.

Washington resident

A person physically residing and maintaining a residence in the state of Washington. You must be a Washington resident to be eligible for Basic Health. To be considered a Washington resident, members who are temporarily out of Washington for any reason:

- May be required to prove their intent to return to Washington State; and
- May not be out of Washington State for more than three consecutive calendar months.

Dependent children who are attending school out of state may be considered residents if they are out of state during the school year, as long as their primary residence is in Washington State and they return to Washington State during breaks. Dependent children attending school out of state may be required to provide proof that they pay out-of-state tuition, vote in Washington, and file income taxes using a Washington address.

Your residence may be a home you own or are purchasing or renting, a shelter or other physical location where you are staying in lieu of a home, or another person's home.

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Keep *Hot Policy Pages* and other updates here

Hot Policy Pages are important updates to this *Member Handbook* and are one way Basic Health provides you with official notice of program changes; you will receive them periodically, usually with your monthly billing statement. Keep these updates handy, along with this *Member Handbook* and other information you receive from Basic Health, so that you have the information you need to make the most of your Basic Health coverage.